

Division of Health Care Facilities

PRINTED: 01/18/2011
FORM APPROVED

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (13) PROPOSED SURVEILLANCE IDENTIFICATION NUMBER TN5403 | (12) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | (14) DATE SURVEY COMPLETED 01/04/2011 |
| NAME OF PROVIDER OR SUPPLIER MCMINN MEMORIAL NURSING HOME & REHA | | STREET ADDRESS, CITY, STATE, ZIP CODE 888 HWY 411 NORTH ETOWAH, TN 37331 | | |
| (24) ID PREFIX TAG N 002 | (23) ID PREFIX TAG N 002 | (25) DATE 01/20/11 | | |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| <p>During the Life Safety portion of the survey, there were no deficiencies cited from 1200-B-6, Standards for Nursing Homes.</p> | | <p>- On January 4, 2011 the trash can was removed from blocking the R-fire extinguisher. Staff that was working at that time was inserviced immediately. All other staff were inserviced at the monthly staff meeting January 20, 2011, 1:30 pm. New staff will be inserviced.</p> <p>- Daily checks by dietary staff will check fire extinguishers, pull stations and exit routes for compliance.</p> <p>- Changes include daily monitoring by staff, monthly checks of fire extinguishers by maintenance will advise Safety officer during his inspections.</p> <p>- Monitored by Dietary Supervisor, Safety Officer and added on monthly fire extinguisher check list.</p> | | |

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PROVIDER DIRECTORS OR PROVIDER/SUPPLIER/REGISTRANT SIGNATURE: *Robert J. Miller* TITLE: *TRNG*

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